STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155153	A. BUILDING _____ B. WING _____	C 01/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHWIN	20531 DARDEN RD SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the investigation of Complaint IN00100649.

Complaint IN00100649-Unsubstantiated due to lack of evidence.

Survey date: January 3, 2012

Facility number: 000073
Provider number: 155153
AIM number: 100288820

Survey team:
Bobbie Costigan, RN TC
Vicki Manuwal, RN
Susan Bruck, RN

Census bed type:
SNF/NF: 127
Total: 127

Census payor type:
Medicare: 19
Medicaid: 88
Other: 20
Total: 127

Sample: 3

Healthwin was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint #IN00100649.

Quality review completed 1/10/12
Cathy Emswiller RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE